MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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COMMISSIONERS PRESENT:

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AGENDA ITEM:

Implementation of the Medicare drug benefit
-- Joan Sokolovsky

DR. SOKOLOVSKY: What I'm going to present for you today is what will be the second half of a June chapter that focuses on implementation of the Medicare drug benefit. This is about the processes that have to be gone through when people change drug plans or drug plans enter or exit markets.

Whether Medicare beneficiaries choose drug coverage through Medicare Advantage plans or stand-alone drug plans, their drug plan is very likely to be managed through a pharmacy benefit manager or PBM. PBMs currently manage drug benefits for about 200 million Americans, processing 70 percent of all prescriptions dispensed annually.

The form of this chapter is to look at what happens when a transition takes place, what are the processes that have to be gone through, what are the problems that arise, and what are the implications for implementation of the Medicare drug benefit. To maximize efficiency and cost savings, the Medicare drug benefit depends upon competition among plans. The challenge for the program is to provide opportunities for continued competition while minimizing instability and disruption for beneficiaries.

There are two kinds of changes that we're dealing with here. One where a plan exits a market and all of its enrollees must change drug plans. And the second, when individuals change plans during the annual open seasons. Although some of the issues are different in both cases, whether plans enter and exit the market, or beneficiaries enroll and switch plans, plan sponsors and the Medicare program will have to ensure that the transition from management of the drug benefit by one PBM to another PBM is as seamless as possible.

The process of making drug plan transitions is one that there's virtually no research on but a great deal of anecdotal reports of the difficulties involved. Our study tried to provide some research on it. We focused on the experiences of plan sponsors that changed PBMs to see what issues they encountered and what were some of the best practices that minimized problems. Our goal was to see what policy lessons could be learned.

It was a three-part study that began with structured interviews with experts who had experience with drug benefit management. Our interviewees included

representatives from PBMs, pharmacists, consultants with experience managing these kinds of transitions, representatives from health plans, and other large organizations that have recently changed PBMs. These experts not only gave us their experience but also recommended sites for us to visit. In the second part of a study we conducted two site visits, one at a large public organization and one large private organization that had both recently changed PBMs. At these sites we met with benefit managers and other executives that were involved in the decision to change PBMs. We met with physicians and pharmacists, union officials, and external consultants employed by the organization to help manage the transition process. Finally, at each site we conducted two focus groups, one with active employees and one with retirees where they gave us the sense of what their experience was during the transition.

So first I'd like to give you some idea of the process. The first question you would ask is, why does an organization make the change? The most frequent answer was cost. They thought that they could get better cost savings from another PBM. They weren't satisfied with the cost savings they were getting from their current PBM. Some of our interviewees also mentioned service problems.

It was a very hard decision to make to change PBMs because everybody agreed that it was a very time-consuming and resource-consuming process. Universally we heard that to do it well it takes at least six months. One plan we heard from did it in 90 days but had continuing and what they considered very major problems.

Once they make the decision to change they tend to issue an RFP asking for proposals from PBMs about how much they would charge and what they would do, et cetera. At this point, if the benefit is going to change, and by change it usually means higher copays, stricter formularies or some change that enrollees might not like, some plans would begin the communication process at that time trying to explain why they're going to have to make this change.

Once the new plan is chosen, this is when the data transfers have to take place. There are two kinds of data transfers. One is the data from one PBM to another. This would include who's enrolled, all the enrollment information. It includes if people are on maintenance medications and they have open refills where the physician has written a prescription for say a hypertension drug that can be continually renewed before the person has a come back to the physician, that open refill information has been transferred from one PBM to another.

This information and also the new benefit

structure, what copays will be charged, what is the current formulary, what is the deductible, all have to be electronically available at the pharmacies on the day that the new plan takes over, usually January 1st.

The new plan has to issue cards that the enrollee can take to the pharmacy on that day to process a prescription. And all of the plans emphasized that it's important to have this data in advance so you can test the data transfers and whatever bugs are in the system they can be fixed.

Lastly, you have to provide notice to enrollees, but also to pharmacists, and if possible physicians. They say that the earlier you can do it, the better.

When we look at the problems there is one piece of very good news that comes out on top which is that in general transfers of the big data sets from one PBM to another are much easier now than they used to be, much more streamlined because plans are using standardized code systems. But that doesn't mean that problems don't occur, and when they occur, for example, if enrollment data isn't transferred or the new cards are not received by the enrollee before the date of the transfer when they go to the pharmacy they cannot get their medication. This is particularly a problem if the open refills, those maintenance medication prescriptions are not transferred because in that case, even if the beneficiary is willing to pay cash out of pocket, the pharmacist cannot legally dispense the medication because there's no prescription.

Sometimes incorrect copayment amounts are transferred, but the biggest problem that we heard from virtually all of our interviewees was the issue of prior authorizations. Prior authorization is when a plan asks the physician to get approval in advance for dispensing a particular medication. It could be because it's a very expensive medications like one of those new self-injectable biotech drugs that can be very, very expensive. It could be for a drug that's subject to overuse like some of the painkillers that people may become addicted to. It also can be a situation where a drug is not on the formulary but the patient has already gotten an exception because the drug that's on the formulary doesn't work for them.

In all of these cases plans had a great deal of trouble getting that information transferred from one plan to another.

When it doesn't work it frequently entails extra physician visits. Sometimes if it's a whole plan and people are using the same physicians -- we had one case where physicians had to rewrite every prescription for every kind of open refill and every prior authorization that they had

issued.

One example where it did work was one plan that thought about this very carefully in advance and actually sent to every enrollee a separate list with other drugs that would require prior authorization. They were the only plan that never reported any problems on this issue.

Even with the best communication strategies we found that many times the first time that enrollees and physicians were aware that the formulary had changed with the new benefit was when the patient arrived at the pharmacy counter. This is something we'll talk about a bit later.

Another problem that we heard about were changes in mail-order procedures. This was a case where a plan would use a different mail order system than the previous plan, the drugs would look different and the beneficiaries would get drugs, usually generic drugs. The old ones might have been blue. This is a different company; it's red, and they're not sure that they're getting the right medication anymore.

It's clear that some of these problems are easily and quickly dealt with them. Some of that seem to take much longer.

So what are the implications for the Medicare drug benefit? I'm sure it's going to come as a surprise to nobody to say that an effective communication strategy is critical. Everybody said, you've got to tell people lots of times, you've got to tell them simply, and you've got to tell them in different ways. Send them a letter, send them e-mail, have advertisements, do a lot of different things because no one thing will reach everybody.

Second thing was time. Again this was something that came up everywhere. You need time to test the data transfers and prepare targeted mailings to people who are going to be affected. For Medicare there's a tension between giving plans enough time to develop their bids and negotiate with CMS and making sure that there's enough time for beneficiaries to learn about their choices, and on the other hand, giving plans the time to transfer the required information.

Data transfers will be much more complicated for Medicare because the plan will have to have systems in place at the pharmacy where they can track copay levels by income, and also the level of out-of-pocket spending. Plans right now -- PBMs have told us that right now they don't systems in place that can track the level of individual spending at the pharmacy counter, although some of them can do it through their own mail-order systems.

There also, we think, should be contract requirements that plans have procedures in place not only

how are they going to get the data from the old PBM when they get new enrollees, but also what are the requirements for handling data when enrollees leave the plans. We found that there were situations where the old PBM, not many, but a couple where the old PBM left on a bad note and transferred no information. We think that Medicare -- that it would be important to put in the contract, make sure that doesn't happen.

Lastly, we think it's important to provide information in advance to pharmacists and physicians. It seems that no matter how good the communication strategy is many people will first learn about the changes from the pharmacist or their physician. Making sure that they have this information well in advance is important because they will be doing much of the problem-solving and education anyway.

It may be hard, on the other hand, to notify physicians because it won't be clear necessarily to the new plan who would be the relevant physician to notify.

As I said before, this study, along with what you heard in the March meeting on formularies will be part of a June chapter on implementation of the drug benefit. Jack Hoadley, who is sitting next to me here, is the head of a team of researchers at Georgetown University and NORC at the University of Chicago and they've been working with us on a set of implementation issues. Jack is going to present to you now our preliminary results from a study on state roles in implementing the low-income drug benefit. This won't be part of the June report but will be a later study. We will continue monitoring and looking at implementation issues of the drug benefit.

AGENDA ITEM:

State approaches to implementation of the Medicare drug benefit -- Jack Hoadley, NORC

DR. HOADLEY: Thank you. Appreciate this opportunity to talk about the results of our work. Want to first just review quickly the low-income provisions that we're talking about when we talk to state folks and some other people in this project. We really talked to them both about the discount card program and the eventual Part D benefit. As you certainly know, the discount card is very much in real time right now, so as we did our interviews we really were seeing a moving target as we talked to people. Card sponsors were selected in March. Beneficiary enrollment will start in a few weeks and the cards will generally be effective in June.

As you know, beneficiaries can select one Medicare-sponsored card which normally would have an enrollment fee of no more than $30, but in the case of the low-income beneficiaries or at least those whose incomes are below 135 percent of poverty and are not in Medicaid or some other drug coverage, they'll be eligible for transitional assistance of $600 for each of the two years of this program as well as waiving that enrollment fee.

we turn to the Part D benefit in January 2006, low-income beneficiaries -- all beneficiaries that want to participate in the benefit will need to select a Part D plan, and that includes the beneficiaries who are currently on Medicaid. So again, that's one of the areas where the states are affected by this. Low-income beneficiaries, as I'm sure you know, are subsidized. While the details of the subsidy are complicated, generally those up to 150 percent of poverty or Medicaid enrolled get some portion of a subsidy. And then states can supplement coverage for any beneficiaries but can't get federal match for that supplementation. So these are some of the context items that affect the folks that were talking to us.

Basically we're mostly dealing with the topics of education and outreach and there really are three goals that need to occur. One is the need to explain the changes in prescription drug coverage to beneficiaries. Another is finding and enrolling individuals who are eligible, particularly for the low-income benefits, the transitional assistance for the discount cards or low-income subsidies for the Part D benefit. Finally, the potential to provide help to Medicare beneficiaries in assessing their options and choosing among the different discount cards right now or the prescription drug plans later.

So our project was to interview a number of experts in this area, particularly state officials and others knowledgeable about the issues facing the states and their interactions with low-income beneficiaries to find out how states are perceiving their role, what are they doing now and what do they plan to do as they look forward to 2006, and what are some of the challenges they face. We conducted a total of 19 telephone interviews with mostly current and former state officials, a few other policy

experts and advocates for low-income beneficiaries. We covered a total of 13 states amongst our various interviews, and as you see, we covered different kinds of programs within the states.

I put the dates very precisely here. We conducted our interviews between March 10th and April 14, so we really were straddling a number of the key events, particularly the announcement of the discount card sponsors and some of the other things relating to that. So our messages to some degree changed as it went along.

So first I'll talk about the discount card portion. What is it that states perceive as their roles and responsibilities? In many cases the first thing they told us is that they perceive this to be a federal responsibility and not really a state issue. One of the quotes was, when it's a federal program we think the feds will do the communication. These are Medicare folks, why should we have to do anything?

Now obviously their message became more nuanced and different as we went along but there really was often the first message we heard is, why has this become our problem? We didn't pass this new program and it's a lot of new work for us. Some of that's about funding, but a lot of it is about really trying to figure out and learn about a program that the federal government is operating and they're only trying to keep up and learn what's going on.

States also vary a lot in their capacity and their interest and their enthusiasm for dealing with these issues. For example, the SHIP programs, the health insurance counseling programs vary a lot across states. Some have are very active, very effective programs that really give them a big base to build on. Other states have much smaller programs, ones that don't have nearly the kind of experience and capacity to do the kind of work that's potentially here to be done.

States also varying incentives, and one particular important area for that is the state pharmacy assistance programs. Those states that have pharmacy assistance programs, particularly now when we're talking about the discount card, they have a very strong incentive because if their enrollees are eligible for and can enrollee in the transitional assistance, that's $600 that the federal government will pick up of the drug cost that the state funds don't have to pay for. So they have a strong incentive and we'll come back to that point in a minute.

Just to elaborate on that, I think again people are probably familiar with the state pharmacy assistance programs, but there are 19 or 20 operating programs around the states, another six or eight that are authorized but not operating. Most of these are fully state funded although some are operating with federal dollars under waivers. The programs vary a lot. There's a handful of large, long-established programs like New York, New Jersey, Pennsylvania, Illinois. Other states they're smaller just because they're small states but still are long-running active programs, and then some others that are relatively small and/or relatively new. So depending on the different situations in those states again what we heard from them was often different.

So what is it states are doing about the discount cards? A few of them by the time to talked to them had begun to do some kind of outreach. In some cases though they said, this is still early. One told us, we're still trying to figure out what this piece of legislation is, understand all its elements so we can coordinate within the apartment. That's kind of where everybody is at this point. But things are starting to move and we really actually saw the pace pick up across the month or so of our interviews. We heard about one SHIP program that was already holding sessions during the month of April to tell beneficiaries in their state what to expect, even though they couldn't yet counsel them specifically about how to go about picking one card versus another.

We saw the state action more so in the states that had either active SHIP programs or active pharmacy assistance programs, again where the incentives greater. We saw a lot less when we talked to Medicaid folks. Generally because Medicaid beneficiaries are not eligible for the discount cards the Medicaid folks said this really isn't our issue for this part. We'll be involved in the drug benefit in a year or so, but not right now.

The planning really is going on very vigorously on the discount card program and that's something if I'd talked to you after our first handful of interviews I wouldn't have said. But as we moved we could really see that pace picking up. Yet at the same time they're also waiting to see what CMS is going to tell them about the various issues and what about the federal money that's going to come through to assist the counseling.

So what is a typical state plan for outreach? In many cases they rely on Medicare. They've been told that Medicare will send a letter to all beneficiaries, that the Social Security Administration will send a targeted letter to all low-income beneficiaries who might be eligible for transitional assistance. Card sponsors will soon be reaching out as well. Then what the states figures that they can do, at least the ones who seem to be more interested and active in doing this, is to provide follow up messages, to have letters that follow the federal letters and give them more information specific to the situation to might apply in that state.

In particular, again, that has to do with the states with strong SHIP programs who are training volunteers and preparing to do one-on-one counseling, which is one of the strengths of the SHIP programs. They're really expecting to sit down with those beneficiaries who come to them and try to help them figure out whether to get a card and if so what card. But also the states with pharmacy assistance programs are really gearing up. Some have issued RFPs to designate a particular card sponsor. Some have already sent out letters to begin to tell people what to do. In some cases the first message is, don't get a card until you hear more from us. Then they'll have another mailing or other communication going out to say, here's the way we think you can take advantage of this program.

States are also beginning, and just this week CMS, or at the end of last week, CMS announced some options for auto-enrollment

and standardized enrollment forms that states could use, and the states are really, at least the more active ones, are really prepared to start doing that. Again, Medicaid agencies, they're just really not seeing this as a big part of what they're doing.

What are some of the communication strategies? Again, mailings are part of it. But they did point out to us that mailings can sometimes raise more problems because they raised questions, and they've got to be geared up to be able to have a hotline or a phone line to follow up on the questions that come up in the mailings. They've had that experience with some of the mailings that went out on the Medicare savings program in previous years and if they weren't geared up and ready for the onslaught of calls that followed then it actually became a burden to them.

They're also looking where they have existing mailings going out to beneficiaries where they can add a message about the discount card. One state told us that they were interested in trying to communicate with providers, to physicians, to pharmacists and would use the periodic letters that go out through Medicaid or through the state pharmacy assistance programs to add messages about the discount card. Also do the same thing on the web sites that they use to communicate with providers. So you really get this variety of strategies.

What are some of the challenges that states will face? Administrative capacity is certainly one. The challenges of coordinating efforts across the different state agencies that are involved, coordinating between Medicaid and an aging department, coordinating within the subagencies of an aging department. We heard a lot about, especially when you're operating in a short timeframe, how hard it is to bring all the relevant parties together and get them all on the same message. There's the potential for competing messages coming from CMS, from the states, from the card sponsors and they're all trying to work hard to try to make sure that doesn't happen. But when you're working on this short timeframe, it's difficult.

Also challenges around reaching some of the most vulnerable populations, the disabled, the institutionalized, the frail elderly at home or in assisted living. Most states acknowledge that those are hard audiences to reach and at this point and this fast pace they don't really have magic bullet strategies to how to reach out, although some have tried to, in the past, develop particular targeted communication approaches for those.

Let's turn then to the drug benefit that goes into effect in 2006. As we asked people about that our first message was usually, again, a federal responsibility. It's not our problem but we'll somehow deal with it. But they really also gave us an equal message that they did understand that this was a population, particularly the ones who were enrolled in the state programs like Medicaid and pharmacy assistance that they felt a responsibility to. They understood that they were part of the partnership that needed to make this work. But that came after they first complained, we've got this new job to do and it's not of our making.

What is it that states are doing relative to Part D benefit

in 2006? One person basically said, it's still too early. That respondent told us that 2006 is a millennium away in state time. We're just not there yet. Somebody else said, there's nothing for anyone to do right now. It's too soon. There's much that we're trying to resolve with CMS. Until we have more information from the federal government about what they are telling beneficiaries, only then will we have a sense of how we want to communicate and what the messages are we want to communicate. So again their real message was, it's early to figure what to do.

It's also that the circumstances are very different. Again, Part D versus the discount card is a different set of messages, and they're having to work hard to absorb the messages for the discount card and it's going to be different. So for example, you tell a Medicaid beneficiary, right now the discount cards aren't relevant to you. You have coverage through Medicaid. You don't need the discount card. Next year they've got to turn around and tell those same beneficiaries, now it's Medicare Part D. You do have to be worried about this. You need to enroll in Part D and need to select a plan. So they're just beginning to learn really the split of the messages that has to happen.

Same with the state pharmacy assistance programs. Right now they're thinking about those that are eligible for transitional assistance or ones we want to get enrolled in that. They've got to also be now thinking about how to create a wraparound, or if they want to create a wraparound Medicare to decide what to do. So outreach and education will only come after these policy issues.

We even had one respondent say, I don't want to get too far ahead because for all I know the federal government will change the program again before 2006, and it will look different by the time we're implementing it, for whatever that's worth.

So what outreaches, again, will the states face in 2006? It's really very similar to what they faced for the discount card but it's more intensified because there's a lot more to do. As I said, the messages will be different. The messages need to go to all beneficiaries, not just a smaller number that may find the discount card relevant to their situation. But again there's a lot of policy options. We don't know yet what the geographic regions will look like, what there will be that focuses on nursing home residents. A lot of the specific policy issues that will effect how the states formulate messages to do outreach and communication haven't been determined yet.

Nursing home is a particularly interesting question because obviously many, many nursing home residents are Medicaid beneficiaries and the pharmacy situation is different there. But it's really something that we were told both by states and by, in one case, a representative of the nursing home industry, it's just something that's just early. We don't know yet how that's going to work out but we know it's important and we know we need to worry about it. Again, a challenge is going to continue to be how to communicate with the various kinds of vulnerable beneficiaries that states need to deal with.

Some what were our conclusions? First, that outreach is critical in any kind of program where participation is voluntary.

States recognize that. They know that they have a role in it, even if it is the federal government's program and the feds started them down this road. They know that they play an important role to try to protect their states' residents.

They also tell us that the federal outreach is tremendously important and that's where it's got to start. And they know that if beneficiaries get messages from a trusted source like Medicare or like the Social Security Administration, that's something that is the starting point for their understanding of the program.

States do understand that they can be important partners in implementing the benefit and have, as we said, on the discount card really started to take actions to be partners and to be involved in helping on that. 2006 is a millennium away for them and they just don't know yet what they're going to need to do but they know they will do something.

They also pointed out the role of not just the SHIP programs that depend on volunteers from the community but some of the community-based organizations that they typically work in partnership with, whether it's advocacy organizations, or senior centers, or other kinds of senior and aging organizations. They know those groups are going to be important as well as, and I didn't put it on this slide, but the physicians and the pharmacists that people turn to. That's one of the common points between the findings that Joan was talking about and what we found here.

Finally, anytime you talk about the states, we know that the states' levels of investment, effective, enthusiasm are going to vary considerably and it's going to be affected by some of the differences that we've talked about like whether or not they have a state pharmacy assistance program, and the type of enrollment and program that they had under their Medicaid.

So that's the end of my comments.

DR. NEWHOUSE: Thank you both for a set of interesting and useful talks. I wondered, Joan, if there was anything to be gained by looking at the experience of changing fiscal intermediaries or carriers in terms of handoff from one carrier to another? I don't know that you need more material, but since you kept saying there isn't really a lot of relevant information here I wondered if there was anything there.

The second point I wanted to make is just a more conceptual point, that some of the issues you are raising would be alleviated if we had followed a path that was more like the commercial model and one had a single plan for a geographic area for a limited period of time and then periodically re-bid it. That, it seemed to me would not eliminate transitions or changes in formularies but it probably would reduce some of the noise here.

DR. SOKOLOVSKY: As far as the fiscal intermediaries and carriers, that's a wonderful idea and I have to admit that never even occurred to me. I don't think it could be part of the June chapter but it's definitely something to look at.

MR. HACKBARTH: Isn't a more analogous situation a transitional among private plans under Medicare Advantage? Because part of the challenge here is that if you're the new plan

your new enrollee could come from any number of different sources, each of which had different formularies, different rules, as opposed to an employer transition, the commercial model where everybody operated under one set of rules and you've got to educate them about a new set of rules. There are just more permutations that you have to deal with under this structure. The private plan situation under Medicare seems like the most analogous situation to me.

DR. SOKOLOVSKY: Absolutely. On our formulary project we did talk to a lot of plans that offer Medicare Advantage and heard many of the same issues but because of payment changes, generally speaking the drug benefit in the past couple of years has been diminished enough that these issues were much less.

MR. SMITH: Thank you, both. This was useful if sobering. Joan, I was struck in the mailing materials by two references, one is on page 12, one is on page 18. They're not specifically important but they both suggested that beneficiaries' price sensitivity led them not to take drugs at all rather than to move to something in a lower copay tier. That's striking and troubling and gets to a lot of the questions that both of you raised about what does the information look like, how do we communicate people both about formulary structure but also about price tiers in order to help people figure out where they ought to go.

But it also raises the question of how will people respond -- will people respond to closed formularies that in some way limit their ability to take the drug that their doc tells them to? Will they respond the same way that the research suggests that they do on the basis of higher tiered drugs that are prescribed? That really does suggest that we need a mechanism to tailor the communication almost one-on-one, which just seems unbelievably daunting for a lot of the reasons, Jack, that you identified. But there isn't some way to do this on a broad basis, particularly if individuals respond in the way that the research you cite suggests they do, by not taking the drugs at all.

DR. SOKOLOVSKY: I don't know exactly what to say. The research doesn't say that everybody will respond that way, but there is a significant minority of people who do respond that way, and I don't know the answer to that problem.

DR. MILLER: Could I just say one thing about this? I think there's two different issues here. One is getting down to the retail level of dealing the patient. I think when Joan was talking about how to communicate, be sure that you're communicating with the pharmacist and the physician, because some of that can happen there.

But then there's the second question of how people respond to tiers, and there are some things recently in the literature that raise the point that you're making.

DR. REISCHAUER: Thank you, both, for interesting presentations. Joan, I found your material particularly interesting as someone who is considering shifting the PBM of the organization that I run and its affected my thinking about it.

I really wondered how much of this was relevant to the

Medicare situation. What you're talking about, the employer market, is group and it's mandatory. I make a decision that the Urban Institute employers are going to go from one to another. This is individual and voluntary. By voluntary what I mean is, somebody is in a plan -- we're talking about after the thing is up and running and some of what you have is relevant to the getting it up and running but not to the ongoing it strikes me.

So I'm an individual and I'm dissatisfied with my current provider so immediately I've made some decisions, I'm thinking about things, I'm looking at the drugs that are covered here and aren't covered there and how they're covered, or my daughter is doing it for me. This is a very different kind of the situation from suddenly I send all my staff a new little white card that they have no idea really what has happened, and I've sent them memos during the previous three months which they have thrown in the wastebasket without reading or taken it home and said to their spouse, you read this and he or she has thrown it away. It's a very different kind of situation.

Then secondly, I would assume, maybe incorrectly, that CMS in going to specify a bunch of handoff procedures. A minimum dataset that has to be transferred from one company to another in a standardized form and during open enrollment period there will be a very routinized way of handling off this stuff. It's going to be a problem, it strikes me, in two instances. One is where in the middle of the year I move from Boston to Arizona and I have to shift plans. My guess even there is that, that judging from the discount card, that all of these are going to be national plans, unless I'm in a Medicare Advantage plan. These are going to offer services everywhere.

The other possibility -- I see people shaking their heads, but the other possibility is that a plan that I signed up for leaves an area and therefore there's a big group of people who have to -- but this is during open enrollment -- shift. We can worry about that but I really don't think these are going to be quite the same kinds of problems that arise in the employer-sponsored environment.

Will there be dropped balls here and there? Yes, but horrendous, I don't think.

DR. SOKOLOVSKY: I think what I want to say is, yes, the model is different and I did try to reflect that in the writing that some of these problems won't be the same problems, won't occur. But I think that some of the things we learned are, in some ways, exactly what you mentioned. For example, one of the things we would like to make sure when CMS comes out with its regulations is that the handoffs are specified in the contracts, both for old PBMs and for new PBMs.

The second thing we learned is that some of the things are not routinized. Every plan has prior authorizations. They don't have a way of transferring smoothly that kind of data.

DR. REISCHAUER: But right now these are cooperative relationships among private enterprises which don't have to cooperate and one is snatching the other guy's business. This is providing a service that's paid for largely through government funds and I would presume that the federal government is going to

specify the handoff of prior authorizations and existing prescriptions. I would hope so.

DR. MILLER: I think that's the point, is we wanted to point out the edges on the current system and I think you've just put your finger on a couple places, the open scripts, the pre-auth where under the current rules those are handled on a retail basis. In this population they may be a much bigger issue. You're right, it may be that people at CMS will look at this and say, we've already thought of this. But we wanted to make sure that we walked through with the current state-of-the-art and said, these are the places where things get rough.

I also think Joan's point about getting to the physician and the pharmacist is something to emphasize in the terms of the communication strategy, because I think a lot of it will get hit there.

DR. REISCHAUER: Can't we be even stronger than -- we're saying, in the private world these are problems, and go the next step and say, in this new world regulations and the way we write contracts can reduce them.

DR. MILLER: I think that's the intention.

DR. REISCHAUER: Be stronger.

DR. SOKOLOVSKY: That is exactly where we were going. I guess the other point to make is that in general for individuals it may not be a problem but if drug plans, as the years go on, enter and exit markets in the same kind of history then you could see some more problems that could be more similar to the employer problem where you have a lot of people all at once. Again, it won't be as simple where they all move to one other plan but you can still have these large numbers of people who suddenly have to make changes.

DR. HOADLEY: Can I just add a comment from interviews that we did in conjunction with the transitions project, that one of the points that a number of the people mentioned when we got beyond just asking them about their experiences in the private-sector transitions was to ask them a little bit to reflect on what the differences may be in the Medicare world. Obviously many of them are familiar with what is coming. One of the big points that they made is the difference between having an employer who's watching over that process and making sure some of these happen in group, who's the person that's going to look over that process in an individual, one-to-one kind of relationship?

Obviously part of that is what you were just talking about in terms of CMS and I think you've got a good point when you say that people are at least making an active choice in many of these situations to change so they're not just passive recipients, here's a card and a memo. I didn't pay attention to it; now I'm in trouble, so that will certainly help as well.

But there was certainly a lot of concern among the folks that we interviewed that without the employer benefits officer shepherding this process that it potentially could be difficult and some of these steps would be needed.

DR. NELSON: This is very good work and I want to highlight just a couple of the aspects with respect to access and quality, which after all remain a lot of our concern in addition to the

structural configuration and exchange of information so forth that we've been discussing. Every patient that has to change their medication that has been successfully managing a chronic problem like diabetes or heart disease, whatever, has the potential both for hassle and harm. They've been doing well; thank you very much, and now because of formulary changes they have to have their medication program changed and maybe it either doesn't work as well, or they have side effects, or they believe that they have side effects because of some of coincidental event. But in either event it involves discomfort for the patient and hassle for the physician, because you know who they are going to talk to, their physician or their pharmacist.

You discussed grandfathering as a means of minimizing that and I think that's an important concept to show up in our recommendation, at least for certain therapeutic classes or at least for certain periods of time, understanding that some grandfathering may not be in everybody's best interest, but certainly there has to be the provision in order to minimize that problem.

The requirements for refills and prior authorization should be made as a simple and hassle-free as possible. Here again I'm concerned about access, and for physicians, if this turns out to me an enormous increase in the amount of hassle because of unrealistic requirements for writing refills, getting prior authorization, it would be one more incentive to not take any new Medicare patients.

The formularies should be made available through searchable electronic databases, either in a diskette or that they can download from the Internet. Not all physician office by any means have that kind of electronic capability, but it's increasing and can be extremely important assistance in keeping their knowledge of the formulary up-to-date.

Some appeals process needs to be incorporated in this, I believe. At least should be required of the PBMs for uncommon but important drugs may not be on the formulary just because they're used so uncommonly but are important; some orphan drugs and that kind of thing. There should be an appeals mechanism because it seems to me that a Medicare patient's need for a certain drug ought not to be ignored just because it's rare.

Finally, medical organizations and pharmaceutical organizations, other professional organizations, nursing and so forth, should be used in the communication process. They all have communication vehicles with their members. They probably will read their journal more readily than they read their mail when it's got government letterhead, so that opportunity ought not to be missed. The same goes with AARP and the other consumer groups with respect to the notification process. Certainly we could consider having in our text some acknowledgment of those opportunities.

MR. DURENBERGER: I found the chapter challenging and very helpful to read. I sit here and listen to people talk about Mary's mom and smile because I am Mary's mom. I'm waiting for the influx of helpful information, because I don't have an employer other than the Federal Employee Health Benefit Plan to

help me make these decisions.

So my comments, like Glenn's and Bob's, are directed to the chapter and the way the chapter is constructed. And I really do believe that because the chapter heading is so promising -- just look at that, Implementation of the Medicare Drug Benefit. What follows after that from our standpoint is really critically important.

So laying it out right away in some longer range context so we're really looking ahead to 2010 or whatever the future may be, through a series of analytical steps that we plan to take in order to advise the Congress on the implementation of the program, to me would be a very helpful way to construct the chapter and all of the information that is contained in this chapter, which is just like chapter one probably of a series of works that we will be doing. And to keep in mind the importance to whom this chapter is directed. Right now it ought to be to 435 people who are the board of directors of the Medicare program who are out there trying to defend whatever they did without the benefit of anything like we have, against the noise someone spoke of which comes basically from two sources.

There are conflicting sources. Part of the noise is simply coming from drug pricing itself. In my part of the world -- and I've spoken to thousands of seniors in the last few months in groups. In my part of the world the pricing issue is way past the benefit issue in terms of what is really important to them. It is really obscuring the benefit issue. The only thing the benefit decisionmaking, whether it's the discount card or something else has going for it right now is the fear that if you don't sign up now or you don't sign up appropriately then you lose or you get a penalty or something like that.

But the two areas I would suggest that our trusted sources, one less than the other, the first is whoever is out there selling it from the board of directors better know what they're selling, and they had better know where to refer people for information.

The second one is, the trusted source so far is nobody that I have seen. It certainly is not SSA and it's not Medicare and its not anything like that. It's the doctor and the pharmacist, and I don't see a lot of investment anywhere in informing -- and it's expensive to do it -- to informing that part of the world that all of us are going to rely on.

MR. MULLER: Both the chapter and your presentations do a very good job, as the other commissioners have mentioned, in laying out the challenges of implementing it so it may be premature to think about where one creates a safety net when some of the problems arise. But my analogy, I think about the plans entering and then exiting M+C and Medicare Advantage, the safety net we've had over the last few years is in fact the doctor and hospital network that keeps serving people even when plans exit. I'd like to ask you to speculate a little bit with us as to where those counterparts may be in this program as plans come and go.

As the chapter that you presented to us as well on information technology pointed out, probably the part of the health care sphere that is most sophisticated in its

computerization is the pharmaceutical medical sector, so probably instant eligibility determinations can be made much more quickly in this arena than it can in other benefit parts of the Medicare program. So the lack of eligibility could be almost instantly ascertained when plans exit as opposed to poster going on for a month or
two.

So what are your thoughts about where some safety net might be as plans come and go? I know it's somewhere down the line, but thinking about that safety net I think is an appropriate thing for us to consider.

DR. SOKOLOVSKY: Are you talking about the safety net for information or a safety net to provide drugs?

MR. MULLER: A safety net for the beneficiary if the old plan has pulled out and the new plan hasn't yet made the successful communication, and contact, and sign up, et cetera, with them. As you pointed out, going forth now with 18 months of planning, which based on what you said and what Nancy-Ann says, an incredibly tight timetable, when people have to start doing it in 24 hours or 24 days it gets even more difficult.

DR. SOKOLOVSKY: When those kinds of problems happen it is going to be at the pharmacy that people are going to find out that they have a problem, and it is going to be the pharmacist who is likely to be the one who is going to be trying to manage that. The pharmacist, who cannot write prescriptions, is going to have to be in contact with the physician, and that is in fact what happens when there are problems in these private-sector transitions now as well. There's a lot of additional work for the pharmacist and for the physician.

MR. MULLER: But they're also pretty efficient in saying, I can't help.

DR. SOKOLOVSKY: The ones that we spoke to spoke about the kinds of works they did to help.

DR. NEWHOUSE: Ralph's scenario raises the question about what happens if a plan pulls out and the beneficiary hasn't signed up for a new plan, or finds that out when they get to the pharmacy. Presumably they're not covered. But then what happens next?

DR. SOKOLOVSKY: That's a really interesting point. If a plan pulls out and the beneficiary doesn't sign with someone else, it seems to me that's a whole separate issue that really has to be explored, and I don't know the answer offhand.

DR. NEWHOUSE: That's surely going to happen.

MR. FEEZOR: Joe, I wonder -- that actually was going to be a part of my comment. First off, good chapters. Joan, I found myself nodding. Everything that you had in this chapter were things we confronted in moving 400,000 lives in our self-funded program at CalPERS.

Two points though. I think on the safety net that Ralph is raising and the people who are lost, there's not that employed. Okay, maybe the Secretary maybe could be, but the reality is there's not that employer that has that force. I wonder if the PBMs might not want to look at the model that's used in some of the auto insurance industry, the compulsory pools. Or maybe a

better analogy would be within the old days when every state had it's own Blue Cross plan. They had an interplan bank, or a plan would run that so if there was a lost soul, I show up and my pharmacist says, wait a minute, I don't have you being with Medco, and I say this is lifesaving. And the pharmacy says, wait a minute, and there might be an authority, if you will, as there are in some other insurance, that that sort of account is marked against and the losses in the administration of those lost individuals then in fact gets borne by the entire participating industry.

So I would suggest that we might explore that a bit more in some of our subsequent evaluation.

The one other thing, it was in the chapter but not as explicit as I thought on the lessons we learned. If we learned anything in the last few years in MedicareChoice was the constant changing of benefits really began to cause people a lack of faith and their willingness to participate. Here you probably can do some tinkering on the benefits. And even more pernicious I think can be the formulary changes that I can do every month I guess. If I really am going to be suspect I could probably even do some not so subtle risk and financial impact play by what I'd do with that.

It is brought out in the chapter but I would underscore it, I think you don't want to preclude formulary changes but you want them to be done in a predictable fashion with, as the chapter was excellent in pointing out, with advanced notice to all parties. And it might be that they're done -- if there are changes, they're done at the beginning of a quarter or something like that. I would even say once a year but maybe that's too restrictive -- simply so that people get used to, wait a minute, there may be some changes that affect me and I know where to go to look to find it on the web site or whatever.

DR. ROWE: Just a couple points. There's been a lot of discussion about this. Very interesting stuff. I do think there are already effective communications out there. I visited my mother on Sunday. She's 94 and she showed me a letter she got from Medicare describing the discount drug program, the discount drug card. I thought it was very well done. Now maybe I'm not the average Medicare beneficiary, but she seemed to understand it and it was very clear. So things are starting to happen there. So we should give CMS some credit because we're always beating on them. Obviously they are moving very quickly here.

I wondered whether it was worth hearing a word about what's going to happen to people in long-term care facilities. I was thinking about Bob's comment about this is an individual rather than a group. But the fact is people who are in long-term care facilities get their medications hand-poured by staff and they're purchased right now probably by the nursing home or nursing home chain or whatever through some wholesaler. Then the individuals are probably charged some retail price per pill I guess it varies.

Anyway here we are now, there's a nursing home with 120 people and they're probably all Medicare eligible, and the six different cards are being held. What's going to happen and how

are they going to get the drugs? Or is the nursing home going to contract with one company? These are not necessarily the beneficiaries that the companies are going to be marketing to necessarily, depending upon where the profit is. If it's a percent of the total cost then they might be. So what's going to happen there? I haven't heard much about that.

DR. SOKOLOVSKY: That was an issue that we were particularly interested in and certainly it was part of Jack's project to try to ask exactly those questions. From states we heard very little information to begin with. But there's some things in the law that we know. One is the law says no copayments for beneficiaries in nursing homes, and that was very important. It also says that whoever offers a drug plan has to have a way of coordinating with the pharmacies that provide drug benefits within nursing homes. Exactly what that means is not yet specified, but it is, as you said, an extremely important issue.

DR. HOADLEY: I was just going to add, we did try to explore that question with a couple of our respondents. One of the respondents we had in our project was somebody who formerly had worked in a state program and now was working in a nursing home, company and then others with some of the state people who interact a lot. One of the things I was struck by again was this notion that it really is early in the process. He said, in terms of his own nursing home company that he is involved with, they just haven't begun to think through that.

But what I did get a little speculation on was the notion that one possibility is that a nursing home, especially one whose residents are mostly on Medicaid, that might be important, that might not be depending on the circumstances. But one possibility is that they would either ask the authorized representatives of these residents or strongly recommended to them that they sign up with a particular drug plan that has agreed to work with nursing home pharmacy, because most of these nursing homes as you're pointing out do have special relationships with a particular pharmacy that orients itself and works with nursing homes.

So I think what we'll probably end up seeing, although quite how we get there is not so clear, is some kind of situation where all the residents of a particular nursing home end up getting signed up with a plan that agrees to coordinate and work smoothly with that nursing home. But of course you have got to do that in a way that preserves the choice, the option of beneficiaries to make their choice. It is a voluntary and it's voluntary what plan you pick. It is early but I think it's a really important area to pay attention to.

DR. ROWE: It's more like a group. If you think about a nursing home change, maybe a big one, a national one, then that's a big group. I'm a little concerned that there are going to be some opportunities here that are not going to be particularly advantageous to the Medicare beneficiaries. I think that maybe half of the Medicare beneficiaries in long-term care facilities have cognitive impairment. We've got an enriched population that's vulnerable because they're going to do what the nursing home people suggest. Not that they would suggest a wrong thing, but they're not quite as autonomous because of their living

situation and their cognitive status and health care literacy. So we need a little bit of extra attention to how that gets implemented.

MS. BURKE: Just in follow up to that, and I apologize if you discussed this while I was out of the room. What if any knowledge will we gain from the discount card in answering some of these issues? That is, how one either informs people or essentially gets that information and also gets participation. Will we have gained experienced or will that be transferable in any sense in terms of our knowledge of what -- in the context of nursing home patients but generally?

DR. SOKOLOVSKY: Funny you should ask that question because as it happens, in this series of work that we're doing with Georgetown and NORC the next project is, what are the lessons that we're learning from the discount card that will be applicable to Part D benefits, and it's exactly those questions that we are looking at.

MS. BURKE: I'd like then, as Jack suggested, a further discussion as we go along in terms of what we hear in that context would be helpful.

DR. HOADLEY: One important thing to remember in terms of particularly the nursing home population is for those nursing home beneficiaries who on Medicaid, for the most part the discount card isn't relevant. They won't be involved with that. I think where we will get some things to learn is that not all nursing home residents are on Medicaid, so for those who are private pay or paid by some other kind of long-term care insurance they may find the discount card relevant and the whole process how that part of it works certainly will be opportunities to learn.

DR. REISCHAUER: Just one comment on what I was talking about before. My guess is that the transaction costs for an individual for shifting from one drug plan to another are going to be very high and people are going to end up being very, very sticky. That's just how much of this is going to go on.

But when you read the law lots of stuff isn't specified, and as analysts you can sit down and think, think of the loopholes, think if there's some evil force here that really wants to turn a buck what they could do to the elderly and what they could do to the industry and all of that.

But if I had to predict three years out, I would be very surprised if we saw a lot of pernicious activity. My guess is that the folks who are going to be offering stand-alone drug plans by and large are going to be associated with large PBMs or insurers that have reputations to maintain, that are providing a benefit that is national not local. That there's going to be not a lot of these things, maybe a dozen or so. The competition is going to be pretty fierce. It's going to be hard to appeal to this group and not to that group when the ads are being put on the back of buses to participate. That should the worst happen and there be no offering or somebody withdrawing from a region, which I don't think will occur, there always is the fallback plan. When that's not the case there is the fact that the others will try to be scarfing up that business.

So what we should do is try and direct CMS and attention to providing the protections that will ensure that all of this way does turn out this way, but not pursue the nightmare of the analysts and assume that this is going to take place.

MR. HACKBARTH: Let me sound my agreement with that, and in particular I think it's important for the people in the audience to understand that just the nature of these things, we're exploring something new and different and there's a tendency, a natural tendency I think to try to identify potential problems. Certainly there's a lot of complexity and a lot of opportunity for things to go amiss. But keep it in context.

We're not rendering judgments, but trying to learn, understand, anticipate, and help other people anticipate. Certainly as Jack pointed out, a lot of work is being done to make it go well, and we need to from time to time acknowledge that and recognize that.

So think you, Jack and Joan, for excellent work on this and we need to move on to our next topic which is defining long-term care hospitals.